

6726

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville			c. LENGTH OF STAY IN 1b 50 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS No		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Abbott				4. DATE OF DEATH Month 7 Day 1 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/1877		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Deals Island, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Abbott				14. MOTHER'S MAIDEN NAME Louisa Webster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Thurman Abbott, Toddville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 3, 1959		22c. NAME OF CEMETERY OR CREMATORY ZION CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) ANDREWS MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR JUN 3 59	
				24b. REGISTRAR'S SIGNATURE <i>Charles L. Hines</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
ADDRESS OF DECEASED [REDACTED]		ADDRESS OF EXAMINER [REDACTED]		ADDRESS OF WITNESS [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
ZIP CODE [REDACTED]		TELEPHONE [REDACTED]		FAX [REDACTED]	
MEDICAL HISTORY [REDACTED]		PHYSICAL EXAMINATION [REDACTED]		LABORATORY TESTS [REDACTED]	
RADIOLOGICAL EXAMINATIONS [REDACTED]		PATHOLOGICAL FINDINGS [REDACTED]		TOXICOLOGICAL ANALYSES [REDACTED]	
OTHER FINDINGS [REDACTED]		CONCLUSIONS [REDACTED]		RECOMMENDATIONS [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
ADDRESS OF EXAMINER [REDACTED]		ADDRESS OF DECEASED [REDACTED]		ADDRESS OF WITNESS [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
ZIP CODE [REDACTED]		TELEPHONE [REDACTED]		FAX [REDACTED]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

6727 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>7 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg 05X-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S.S. State Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>6</u> Day <u>-28-</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/67</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmills</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Adams</u>				14. MOTHER'S MAIDEN NAME <u>Belle O'Brien</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Records S.S.H. Camping</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Proton pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor in dining room</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12-15</u> P. M. <u>4-23-1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home at Camping, Wor. Md.</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Thurlock Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry E. Darby Seaford</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thrus</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06704

6711

Items 8 & 9 Film G244 7/8/59 cap
Item #14 - Film G244-7/10/59-mb

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAKLEY STREET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE d. STREET ADDRESS 1 OAKLEY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle BARKLEY Last 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7/11/1876 9. AGE (In years last birthday) 81 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month JUNE Day 30 Year 19 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK 10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS STORE 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM F BARKEEY		14. MOTHER'S MAIDEN NAME AMANDA RUARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 07 7653 INFORMANT Address MRS ELLA WALTER CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Arteriosclerotic Cardio-renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 19 59 to June 30, 19 59 , that I last saw the deceased alive on June 30, 19 59 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Church St. Cambridge, Md. DATE SIGNED 6/30/59 ACTUAL SIGNATURE John Mace Jr. M.D. PHYSICIAN'S NAME (Type) John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LECOMPT FURNAL SERVICE CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR JUL 6 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1943



Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

Stomach

Anterior-posterior Cardio-respiratory

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6712

CERTIFICATE OF DEATH

09027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore St. Hosp.</u>		d. STREET ADDRESS <u>05x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>-</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Lancashire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN Vernon Hood</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Eastern Shore State Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sev yrs.</u> <u>sev. yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Br. Syndrome assoc. with simple Br. d. with Agy.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>59</u> , to <u>6/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>7:14 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D.		DATE SIGNED <u>6/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Simon Virkutis, M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Preston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u> ADDRESS <u>Corral Eastern Md</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

100-27

CERTIFICATE OF DEATH

1912

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>		<p>5. Place of birth</p>		<p>6. Date of death</p>		<p>7. Place of death</p>		<p>8. Cause of death</p>		<p>9. Manner of death</p>		<p>10. Signature of physician</p>		<p>11. Signature of registrar</p>		<p>12. Signature of informant</p>	
<p>13. Name of informant</p>		<p>14. Address of informant</p>		<p>15. Date of completion</p>		<p>16. Name of registrar</p>		<p>17. Address of registrar</p>		<p>18. Date of registration</p>		<p>19. Name of physician</p>		<p>20. Address of physician</p>		<p>21. Date of completion</p>		<p>22. Name of informant</p>		<p>23. Address of informant</p>		<p>24. Date of completion</p>	

100-27

100-27

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 62 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital		d. STREET ADDRESS Edlon Park	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Buena Brinsfield Cook		4. DATE OF DEATH June 28 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Brookview, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Brinsfield		14. MOTHER'S MAIDEN NAME Harriett McAllister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT Brinsfield Cook, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck r. femur. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 Min. 10 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 9040		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Fell in home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9 AM p. m. 6-18- 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 6/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cem.		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leunith L. Thomas		24a. REC'D BY REGISTRAR JUL 2 '59	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

FOR STATE
DEATH CERTIFICATE

1913

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1913

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1913	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		NATURALIZATION	
Maryland		Naturalized	
EDUCATION		OCCUPATION	
High School		Farmer	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
RESIDENCE		SIGNED AND SEALED	
1234 Main St., Baltimore, Md.		J. H. HARRIS, M.D.	
DATE		PLACE	
JAN 15, 1913		BALTIMORE, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6714

CERTIFICATE OF DEATH

06706

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salem</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Davis</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1953</u>
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claudel Davis</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Claudel Davis, Salem, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>108X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Autopsy findings compatible with Rickettsial Disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7-</u> , 19 <u>59</u> , to <u>6-14-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-13-</u> , 19 <u>59</u> , and that death occurred at <u>5:25 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hilton H. Wilson</u>		ADDRESS (Street, city or town, state) <u>232 Cedar St. Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Hilton M. Wilson</u>		DATE SIGNED <u>6-19-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard H. Wilson</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

28520

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8591

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09029

1. PLACE OF DEATH a. COUNTY Dorchester - MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 15 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS 2 Talbot Street			
3. NAME OF DECEASED (Type or print) First Martha Middle Ellen Last Dyott				4. DATE OF DEATH Month June Day 27 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 87 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Covey				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07 3359		17. INFORMANT Records E.S.S. Hospital- Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/27/59	
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/59		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Hines				24a. REC'D BY REGISTRAR DATE AUG 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1930-01-15	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Boston, Mass.		Heart Disease		1975-03-10		10:00 AM	
Occupation		Medical History		Manner of Death		Signature of Examiner	
Teacher		Hypertension, Diabetes		Natural		[Signature]	
Usual Residence		Place of Death		Physician's Name		Physician's Address	
123 Main St, Boston		Home		Dr. Smith		456 Oak St, Boston	
Usual Place of Employment		Name of Hospital		Name of Doctor		Name of Nurse	
Boston Public Schools		Massachusetts General Hospital		Dr. Jones		Ms. White	
Name of Informant		Relationship to Deceased		Signature of Informant		Date of Report	
Jane Doe		Wife		[Signature]		1975-03-11	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6728

CERTIFICATE OF DEATH

06707

Reg. Dist. No.

1. PLACE OF DEATH a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE R F D # 3		c. LENGTH OF STAY IN lb 5 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle CORDEIS Last ECKEL		4. DATE OF DEATH Month JUNE Day 23 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 27 1887
9. AGE (In years and last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MGR.		10b. KIND OF BUSINESS OR INDUSTRY STEEL CORP	
11. BIRTHPLACE (State or foreign country) PITTSBURG PENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW ECKEL		14. MOTHER'S MAIDEN NAME FLORENCE B ECKEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS J C ECKEL		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PARKINSON'S DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 3 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 17 1959 , to June 23 1959 , that I last saw the deceased alive on June 16 1959 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md DATE SIGNED 6/24/59 ACTUAL SIGNATURE Alfred R. Maryanov M.D. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF JUNE 25 1959	
22c. NAME OF CEMETERY OR CREMATORY ST JOHN CHURCHYARD		22d. LOCATION (City, town, or county) (State) CONERSVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	
24a. REC'D BY REGISTRAR DATE JUN 25 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

40707
CERTIFICATE OF DEATH

REGISTERED

MARYLAND

CARROLL COUNTY

2 YEARS

1913

NAME: JOHN J. COOPER
AGE: 42
DATE OF BIRTH: NOV 27 1871
PLACE OF BIRTH: WITTEBURG, PENN.
OCCUPATION: FIRST COOK

DECEASED: ALBION WHEEL
BY: JAMES B. KOSKOWSKI
WITNESSES: MRS. J. C. KOSKOWSKI, EMILY KOSKOWSKI

CERTIFICATE NO. 1000
FARMERS & MERCHANTS

CHIEF CLERK: CARROLL

DATE: NOV 23 1913

REGISTERED: CARROLL COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1, Film G244, 6/19/59
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 Years.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hospital, Cambridge, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR D. GREENFIELD		4. DATE OF DEATH Month 6 Day 9 Year 19 59	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Salesman	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Evan A. Greenfield		14. MOTHER'S MAIDEN NAME Caroline E. Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 469-18-5642	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm of the Aorta DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-8-59 , 19__, to 6-9-59 , 19__, that I last saw the deceased alive on 6-9-59 , 19__, and that death occurred at __ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 5-12-59			
ACTUAL SIGNATURE Albert E. Bunker M.D.		PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D. Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/12/59.	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Chapel.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

For use by the

Registrar

General

Statewide Ave.

University Hospital, Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

1951

1951

U.S.A.

Youngstown

Albany

Albany

Cambridge, Mass.

Cambridge, Mass.

1951-1952 The City of Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

1951

1951

Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass.

6/12/52

Cambridge, Mass.

Cambridge, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

CERTIFICATE OF DEATH

Reg. Dist. No.

06709

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8mo.6das.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		d. STREET ADDRESS 20X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Marie Last Holmes		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-87
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William HOLMES		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 422.1 DUE TO Chronic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 11, 1958 , to June 17, 1959 , that I last saw the deceased alive on June 17, 1959 , and that death occurred at 8:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. DeFilippis M.D. E.S.S. Hospital, Cambridge, Md. 6-18-59			
ACTUAL SIGNATURE E. DeFilippis M.D. E.S.S. Hospital, Cambridge, Md. 6-18-59			
PHYSICIAN'S NAME (Type) E. DeFilippis, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-20-59	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Bald. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harley Funeral Home-Catonville, Md.		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6716

CERTIFICATE OF DEATH

06710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few Hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. STREET ADDRESS <u>Hurlock</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Howard</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1899</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Wilsie Cornish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-03-6888</u>		17. INFORMANT Address <u>Mrs. Mary Hopkins, Hurlock, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May 29, 1959</u> , to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>			
DATE SIGNED <u>6-5-59</u>							
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Seltman</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arline E. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF FUNERAL HOME</p>		<p>15. SIGNATURE OF CORONER</p>	
<p>16. SIGNATURE OF JUDGE</p>		<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF HEALTH OFFICER</p>		<p>20. SIGNATURE OF DEPARTMENT OF HEALTH</p>	

CERTIFICATE OF DEATH

06711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliotts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliotts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Riley</u> First <u>Horseman</u> Middle <u>-</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/29/1870</u>
9. AGE (In years, last birthday) <u>89</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boatman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Boat</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Horseman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Miss Lattie Horseman, Elliotts, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR RENAL DISEASE</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 APRIL 1950</u> to <u>13 JUNE 1959</u> , that I last saw the deceased alive on <u>3 JUNE 1959</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter E. Gumbys</u>		ADDRESS (Street, city or town, state) <u>105 CHURCH ST</u> DATE SIGNED <u>6/16/59</u>	
PHYSICIAN'S NAME (Type) <u>WALTER E. GUMBYS JR</u>		<u>CAMBRIDGE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elliotts</u>	22d. LOCATION (City, town, or county) (State) <u>Elliotts, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Talley</u>		ADDRESS <u>East New Market</u>	
24a. RECEIVED BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>JOHN DOE</i>		2. SEX <i>MALE</i>	
3. DATE OF BIRTH <i>1900-01-01</i>		4. PLACE OF BIRTH <i>NEW YORK</i>	
5. OCCUPATION <i>LABORER</i>		6. CAUSE OF DEATH <i>HEART DISEASE</i>	
7. DATE OF DEATH <i>1950-01-01</i>		8. PLACE OF DEATH <i>HOME</i>	
9. TIME OF DEATH <i>10:00 AM</i>		10. SIGNATURE OF DECEASED <i>[Signature]</i>	
11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>	
15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF DECEASED <i>[Signature]</i>	
17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>	
21. SIGNATURE OF DECEASED <i>[Signature]</i>		22. SIGNATURE OF DECEASED <i>[Signature]</i>	
23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>	
27. SIGNATURE OF DECEASED <i>[Signature]</i>		28. SIGNATURE OF DECEASED <i>[Signature]</i>	
29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>	
33. SIGNATURE OF DECEASED <i>[Signature]</i>		34. SIGNATURE OF DECEASED <i>[Signature]</i>	
35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>	
39. SIGNATURE OF DECEASED <i>[Signature]</i>		40. SIGNATURE OF DECEASED <i>[Signature]</i>	
41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>	
45. SIGNATURE OF DECEASED <i>[Signature]</i>		46. SIGNATURE OF DECEASED <i>[Signature]</i>	
47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>	
51. SIGNATURE OF DECEASED <i>[Signature]</i>		52. SIGNATURE OF DECEASED <i>[Signature]</i>	
53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>	
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59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>	
63. SIGNATURE OF DECEASED <i>[Signature]</i>		64. SIGNATURE OF DECEASED <i>[Signature]</i>	
65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>	
69. SIGNATURE OF DECEASED <i>[Signature]</i>		70. SIGNATURE OF DECEASED <i>[Signature]</i>	
71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>	
75. SIGNATURE OF DECEASED <i>[Signature]</i>		76. SIGNATURE OF DECEASED <i>[Signature]</i>	
77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>	
81. SIGNATURE OF DECEASED <i>[Signature]</i>		82. SIGNATURE OF DECEASED <i>[Signature]</i>	
83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>	
87. SIGNATURE OF DECEASED <i>[Signature]</i>		88. SIGNATURE OF DECEASED <i>[Signature]</i>	
89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>	
93. SIGNATURE OF DECEASED <i>[Signature]</i>		94. SIGNATURE OF DECEASED <i>[Signature]</i>	
95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>	
99. SIGNATURE OF DECEASED <i>[Signature]</i>		100. SIGNATURE OF DECEASED <i>[Signature]</i>	

6731

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18 Part 1a, 20b to f; film G-244 7/6/59 rs

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Florida b. COUNTY Leon		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tallahassee 48 x 3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Wadde11's Corner			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Dorsey Johnson			4. DATE OF DEATH Month Day Year June 23 1959		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 1914		9. AGE (In years last birthday) About 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Tallahassee, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Cora Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 262-32-3065	17. INFORMANT Address Viola Johnson, Vineland, New Jersey		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delayed, pending complete autopsy report. 880.0 DUE TO Isopropyl alcohol poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drank rubbing alcohol			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 6/23 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Labor camp shack		20f. (City or town) (County) (State) Hurlock, Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF June 29, 1959	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Fort Pierce, Florida
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

2

09

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF ATTENDING PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED		19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF CLERGYMAN	
21. SIGNATURE OF MINISTER OF GOSPEL		22. SIGNATURE OF CHAPLAIN		23. SIGNATURE OF RABBI		24. SIGNATURE OF OTHER CLERGYMAN		25. SIGNATURE OF OTHER MINISTER	
26. SIGNATURE OF OTHER MINISTER		27. SIGNATURE OF OTHER MINISTER		28. SIGNATURE OF OTHER MINISTER		29. SIGNATURE OF OTHER MINISTER		30. SIGNATURE OF OTHER MINISTER	
31. SIGNATURE OF OTHER MINISTER		32. SIGNATURE OF OTHER MINISTER		33. SIGNATURE OF OTHER MINISTER		34. SIGNATURE OF OTHER MINISTER		35. SIGNATURE OF OTHER MINISTER	
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71. SIGNATURE OF OTHER MINISTER		72. SIGNATURE OF OTHER MINISTER		73. SIGNATURE OF OTHER MINISTER		74. SIGNATURE OF OTHER MINISTER		75. SIGNATURE OF OTHER MINISTER	
76. SIGNATURE OF OTHER MINISTER		77. SIGNATURE OF OTHER MINISTER		78. SIGNATURE OF OTHER MINISTER		79. SIGNATURE OF OTHER MINISTER		80. SIGNATURE OF OTHER MINISTER	
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91. SIGNATURE OF OTHER MINISTER		92. SIGNATURE OF OTHER MINISTER		93. SIGNATURE OF OTHER MINISTER		94. SIGNATURE OF OTHER MINISTER		95. SIGNATURE OF OTHER MINISTER	
96. SIGNATURE OF OTHER MINISTER		97. SIGNATURE OF OTHER MINISTER		98. SIGNATURE OF OTHER MINISTER		99. SIGNATURE OF OTHER MINISTER		100. SIGNATURE OF OTHER MINISTER	

18

6733 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6717

Item 15 Film 6244 6-22-59 et

CERTIFICATE OF DEATH

06714

Reg. Dist. No.

1. PLACE OF DEATH o. DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write nearest town) CAMBRIDGE	c. LENGTH OF STAY IN 1b 2 WEEKS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP,		e. STREET ADDRESS 200 SUNBURST HIGH WAY	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle FRED Last JONES		4. DATE OF DEATH Month JUNE Day 12 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 4 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINE E BOREMAND	10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES B JONES		14. MOTHER'S MAIDEN NAME MARY BLADES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO Yes ?		16. SOCIAL SECURITY NO. UNKNOWN	
INFORMANT MRS LUCY JONES		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embelism 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Phlebo thrombosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hour ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach, intestinal obstruction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 29, 1959 to June 12, 1959 , that I last saw the deceased alive on June 12, 1959 , and that death occurred at 6:27 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lewis M. Burdette M.D.		ADDRESS (Street, city or town, state) 1 Locust St	
PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 14, 1959	22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	24a. REC'D BY REGISTRAR JUN 15 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00130

CERTIFICATE OF DEATH

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Certificate of death

Handwritten notes:
Date of death
Place of death
Cause of death

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MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

10015

CERTIFICATE OF DEATH

8733

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6735

CERTIFICATE OF DEATH

06759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 4 Mo's			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie Reed Messick First Middle Last				4. DATE OF DEATH June 5 1959 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1880	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm Reed				14. MOTHER'S MAIDEN NAME Mahalia Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Eastern Shore State Hospital Cambridge Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH Unk	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 6 1959 to June 5 1959 , that I last saw the deceased alive on June 5 1959 , and that death occurred at 3:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 6-5-59							
ACTUAL SIGNATURE Thomas J. Dredge				PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 8, 1959		22c. NAME OF CEMETERY OR CREMATORY BLOOMERY CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR FEDERALSBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. FRAMPTON & SON, FEDERALSBURG, MD.				24a. REC'D BY REGISTRAR DATE JUN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

10-17-70

8737

AMERICAN FIVE YEAR

10-17-70

10-17-70

10-17-70

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Cambridge</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>2212-2</u>		d. STREET ADDRESS <u>103 Elizabeth st.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene Maurice Messick</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 - 13 - 88</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u>	IF UNDER 24 HRS. Hours <u>70</u> Min. <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Westley Messick</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-30-8743</u>	
17. INFORMANT <u>Records Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic hypertensive C. V. R. Disease</u> DUE TO (c) <u>Fracture, Intertrochanteric Rt, Femur</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brain syndrome assoc, with Senile Brain Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Accidental Fall At home</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>30 May 59</u> a. m. <u>30 May 59</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		DATE SIGNED <u>7 June '59</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff ? M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wico. mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Johnson</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH OFFICE

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED] AGE: [REDACTED]
3. DATE OF BIRTH: [REDACTED]
4. PLACE OF BIRTH: [REDACTED]
5. OCCUPATION: [REDACTED]
6. MARITAL STATUS: [REDACTED]
7. PRESENT ADDRESS: [REDACTED]
8. DATE OF DEATH: [REDACTED]
9. TIME OF DEATH: [REDACTED]
10. PLACE OF DEATH: [REDACTED]
11. CAUSE OF DEATH: [REDACTED]
12. MANNER OF DEATH: [REDACTED]
13. SIGNATURE OF EXAMINER: [REDACTED]
14. SIGNATURE OF ATTENDING PHYSICIAN: [REDACTED]
15. SIGNATURE OF CORONER: [REDACTED]
16. SIGNATURE OF JURY: [REDACTED]
17. SIGNATURE OF WITNESSES: [REDACTED]
18. SIGNATURE OF FUNERAL HOME: [REDACTED]
19. SIGNATURE OF BURIAL PLACE: [REDACTED]
20. SIGNATURE OF OTHER: [REDACTED]

6718

CERTIFICATE OF DEATH

06718

Reg. Dist. No.

1. PLACE OF DEATH o. DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	c. LENGTH OF STAY IN 1b 3 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE E	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.		d. STREET ADDRESS RFD # 3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LYDIA First WRIGHT Middle ORR Last		4. DATE OF DEATH Month JUNE Day 7 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 10, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done or profession of life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) N EW YORK	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM WRIGHT		14. MOTHER'S MAIDEN NAME MARY ELLIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO	16. SOCIAL SECURITY NO. NONE	INFORMANT MR JOHN ORRR Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular renal disease DUE TO Generalized carcinomatosis (c) Carcinoma of right breast			INTERVAL BETWEEN ONSET AND DEATH 4-5 minutes 2 years 18 months 18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- 19 p. m. --	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-13-58 , 19__, to 6-7-59 , 19__, that I last saw the deceased alive on 6-7-59 , 19__, and that death occurred at 9:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 6-8-59			
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. 15 Locust Street, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF JUNE 10, 1959	22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	24a. REC'D BY REGISTRAR DATE JUN 12 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6318

DATE OF DEATH: 10-10-1959

AGE: 3 DAYS

SEX: MALE

TIME: 11:30

PLACE OF DEATH: HOME

TIME: 11:30

WEIGHT: 10 LBS

HEIGHT: 20 IN

ST

DATE OF BIRTH: 10-07-1959

WHITE

MALE

USA

NEW YORK

ON FILE

HOUSE WITH

NEW YORK

WILLIAM BRIDGES

JOHN OWEN CARPENTIER

HANDS

HOME

WIFE

Physician's Signature

Physician's Signature

Physician's Signature

Physician's Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06719

6719

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN IB 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albanus Middle Medford Last Paul		4. DATE OF DEATH Month June Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Months 49 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic self-employed		10b. KIND OF BUSINESS OR INDUSTRY Taylor's Island	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Paul		14. MOTHER'S MAIDEN NAME Myra Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-6717	
17. INFORMANT Mrs. Bertha G. Paul		Address 508 Trenton St., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) Arteriosclerotic cardio vascular renal disease		INTERVAL BETWEEN ONSET AND DEATH 20 mins. 20 mins. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-16 , 19 58 , to 6-16 , 19 59 , that I last saw the deceased alive on 6-16-59 , 19 59 , and that death occurred at 12:30 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.	
DATE 6-16-59		DATE SIGNED 6-16-59	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.		M.D. 15 Locust Street, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Remeth R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JUN 19 59		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

06720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3yr.6mo.2das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Pierce</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-69</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Penn Shade</u>		14. MOTHER'S MAIDEN NAME <u>Mary Southerland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch.Br.Syndrome Assoc. W. Senile Br. Disease, With Psy. Reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1955</u> , to <u>June 24, 1959</u> , that I last saw the deceased alive on <u>June 24, 1959</u> , and that death occurred at <u>2:25A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Currier</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>E.S.S. Hospital, Cambridge, Md.</u> <u>6-24-59</u>	
PHYSICIAN'S NAME (Type) <u>George E. Currier, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brook View Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas M. Miller</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 59</u>	
ADDRESS <u>Rising Sun Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10738

NAME OF DECEASED		LAST NAME		FIRST NAME		MIDDLE NAME	
AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF NURSE		NAME OF ASSISTANT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF NURSE		SIGNATURE OF ASSISTANT	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE	
NAME OF REGISTRAR		NAME OF CLERK		NAME OF ASSISTANT		NAME OF OFFICIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF ASSISTANT		SIGNATURE OF OFFICIAL	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

10738

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06721

6720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 WEEKS		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPS HEAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle SULLENDER Last RUARK		4. DATE OF DEATH Month JUNE 11 Day 19 Year 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 24 1885	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 7 Days 11 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during week preceding death, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN P SULLENDER		14. MOTHER'S MAIDEN NAME MARY PRITCHETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT MR RICHARD C RUARK BISHOPS HEAD MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 10 days 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5/10 19 59 to 6/11 19 59 that I last saw the deceased alive on 6/11 19 59 , and that death occurred at 4:15 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. H. HANKS		M.D. 104 Locust St		DATE SIGNED 6/11/59	
PHYSICIAN'S NAME (Type) W. H. HANKS		ADDRESS (Street, city or town, state) CAMBRIDGE MARYLAND			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF JUNE 14 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK	
22d. LOCATION (City, town, or county) CAMBRIDGE MARYLAND		(State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE		ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

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DOCTOR

DECEASED

RESIDENCE

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DECEASED

CERTIFICATE OF DEATH

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Carroll, John
10/10/1917

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10/10/1917

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6738 CERTIFICATE OF DEATH

06723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHURCH CREEK		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE First Middle JONES Last STEWART		4. DATE OF DEATH Month JUNE 29 Day 19 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 10, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN JONES		14. MOTHER'S MAIDEN NAME SARAH LINTHICUM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS W H HARRISON Address CHURCH CREEK MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 mos under	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/14 , 19 59 , to 6/29 , 19 59 , that I last saw the deceased alive on 6/28 , 19 59 , and that death occurred at 5 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred R. Maryanov M.D.		ADDRESS (Street, city or town, state) 136 RACE ST. CAMBRIDGE, MD	
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		DATE SIGNED 7/1/59	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF JUNE 1 1959	
22c. NAME OF CEMETERY OR CREMATORY OLD TRINITY		22d. LOCATION (City, town, or county) (State) CHURCH CREEK MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR JUL 6 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1. NAME OF DECEASED: JOHN J. JONES
2. SEX: MALE
3. AGE: 40 YEARS
4. DATE OF DEATH: 1910
5. PLACE OF DEATH: NEW YORK
6. CAUSE OF DEATH: HEART DISEASE
7. PLACE OF BIRTH: NEW YORK
8. DATE OF BIRTH: 1870
9. OCCUPATION: CLERK
10. MARITAL STATUS: MARRIED
11. NAME OF SPOUSE: MARY J. JONES
12. NAME OF FATHER: JOHN J. JONES
13. NAME OF MOTHER: MARY J. JONES
14. NAME OF BIRTHPLACE: NEW YORK
15. NAME OF DEATH PLACE: NEW YORK
16. NAME OF BURIAL PLACE: NEW YORK
17. NAME OF FUNERAL HOME: NEW YORK
18. NAME OF MINISTER: NEW YORK
19. NAME OF CHURCH: NEW YORK
20. NAME OF CEMETERY: NEW YORK

21. NAME OF REGISTRAR: JOHN J. JONES
22. DATE OF REGISTRATION: 1910
23. NAME OF COUNTY: NEW YORK
24. NAME OF TOWN: NEW YORK
25. NAME OF VILLAGE: NEW YORK
26. NAME OF CEMETERY: NEW YORK
27. NAME OF FUNERAL HOME: NEW YORK
28. NAME OF MINISTER: NEW YORK
29. NAME OF CHURCH: NEW YORK
30. NAME OF CEMETERY: NEW YORK
31. NAME OF FUNERAL HOME: NEW YORK
32. NAME OF MINISTER: NEW YORK
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94. NAME OF CEMETERY: NEW YORK
95. NAME OF FUNERAL HOME: NEW YORK
96. NAME OF MINISTER: NEW YORK
97. NAME OF CHURCH: NEW YORK
98. NAME OF CEMETERY: NEW YORK
99. NAME OF FUNERAL HOME: NEW YORK
100. NAME OF MINISTER: NEW YORK

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 15yr 6mo 24days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 14X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Oliver Last Taylor, Jr.				4. DATE OF DEATH Month June Day 12 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1920		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min.	IF UNDER 24 HRS. Hours - Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Oliver Taylor, Sr.				14. MOTHER'S MAIDEN NAME Burleigh Newman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. --		17. INFORMANT Address RECORDS: Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy						INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 6/12/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6.15.59		22c. NAME OF CEMETERY OR CREMATORY Calverton Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Renneth L. Thomas</i>				24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE <i>Charles L. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

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6721

CERTIFICATE OF DEATH

06725

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLASGOW NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH HAYES TAYLOR		4. DATE OF DEATH Month Day Year JUNE 9 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED *** DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH N OV. 15, 1886
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TAYLOR HAYES		14. MOTHER'S MAIDEN NAME JOEPHINE SHORTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) UNKNOWN	
17. INFORMANT MR THURMAN SHORTER		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Cerebral arteriosclerosis DUE TO (b) Hypertension Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29-58 , 19____, to 6-9-59 , 19____, that I last saw the deceased alive on 6-9-59 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Albert E. Bunker, M. D. 200 Maryland Ave. Cambridge, Maryland			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF JUNE 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	
24a. REC'D BY REGISTRAR DATE JUN 15 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10335

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

4751

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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Lee Tillery		4. DATE OF DEATH June 21 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1885
9. AGE (In years last birthday) 73 7/4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dudley Tillery		14. MOTHER'S MAIDEN NAME Mamie Tillery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-40-4638A	
17. INFORMANT Mrs. Robert Tillery		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma colon (c) slotting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days ?		INTERVAL BETWEEN ONSET AND DEATH 3 days ?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 6/24/59	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/26/59	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Dor., Md.
23. BURIAL DIRECTOR'S SIGNATURE St. Clair Funeral Home		24a. REC'D BY REGISTRAR JUL 6 59 DATE 24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G244 7-20-59 et
6723
CERTIFICATE OF DEATH

06727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle F Last TOLSON		4. DATE OF DEATH Month JUNE Day 7 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1879
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY BALTO & OHIO RR CO MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM TOLSON		14. MOTHER'S MAIDEN NAME LAURA ROBBINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS GEORGE BENNETT		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Crown Artery Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/4 , 19 59 , to 6/7 , 19 59 , that I last saw the deceased alive on 6/7 , 19 59 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. HANKS		ADDRESS (Street, city or town, state) 104 Locust St CAMBRIDGE Md	
PHYSICIAN'S NAME (Type) W. H. HANKS		DATE SIGNED 6/8/59	
22a. BURIAL, CREMATION, REMOVAL (Type) BURIAL	22b. DATE THEREOF JUNE 10, 1959	22c. NAME OF CEMETERY OR CREMATORY SPEEDDENS CEMETERY	22d. LOCATION (City, town, or county) (State) HUDSON MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE		24a. REC'D BY REGISTRAR JUN 12 '59	
ADDRESS CAMBRIDGE MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

00133

CERTIFICATE OF DEATH

2783

DORCHESTER

HARTFORD

DORCHESTER

CHANDLER

3 HOUR

DAVENPORT

201 WEST 2ND AVE

CORNER ONE HARTFORD BOSS

1916

TORONTO

HOWARD

80

AT 11:21 AM

WHITE

MALE

1

USA

HARTFORD

BIRTH & DEATH RECORD

RECORD

ANNA ROSS

WIFE

WILLIAM TOLSON

MRS GEORGE BENNETT CAMPBELL HARTFORD

WIFE

George Benjamin Tolson

George Benjamin Tolson

2/17/22

2/17/22

2/17/22

2/17/22

George Benjamin Tolson

George Benjamin Tolson

HARTFORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06728

6724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. DORCHESTER b. CITY OR TOWN (If outside corporate limits, write nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b USA 6 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY DORCHESTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HOOPERSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL		First Middle Last M TYLER		4. DATE OF DEATH Month Day Year JUNE 17 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12 1876	
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done in last life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN TYLER				14. MOTHER'S MAIDEN NAME ELIZA MEEKIN S			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		INFORMANT Address ACKLEY TYLER FISHING CREEK MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 446X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Chr. Nephritis (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/12 , 19 59 , to 6/14 , 19 59 , that I last saw the deceased alive on 6/14 , 19 59 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks, M.D.		M.D.		ADDRESS (Street, city or town, state) 104 Locust St Cambridge Md		DATE SIGNED 6/15/59	
PHYSICIAN'S NAME (Type) W. H. Hanks, M.D.							
22a. BURIAL, CREMATION, or other (Specify) BURIAL		22b. DATE THEREOF JUNE 16, 1959		22c. NAME OF CEMETERY OR CREMATORY HOOSIER MEMORIAL CEM.		22d. LOCATION (City, town, or county) (State) FISHIN G CREEK MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

00338

CERTIFICATE OF DEATH

1934

DECEASED

Cause of Death

AMERICAN HOSP

NAME

WHITE

SEX

AGE

DATE

DECEASED

DECEASED

CHAIRMAN

ADJUTANT GENERAL

NAME

SEX

Handwritten notes:
Certificate of Death
for
[illegible]
[illegible]
[illegible]

DATE OF DEATH

AGE

NAME

Handwritten notes:
[illegible]
[illegible]
[illegible]

Handwritten notes:
[illegible]
[illegible]
[illegible]

CHAIRMAN

ADJUTANT GENERAL

NAME

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06729

Reg. Dist. No.

1. PLACE OF DEATH DORCHESTER <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NATIONAL CAN CO				d. STREET ADDRESS 116 ACADMEY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILFORD Middle PAUL Last WEBSTER				4. DATE OF DEATH Month JUNE Day 12, Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 21 1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last 12 months or working life, when required) NATIONAL CAN CO		10b. KIND OF BUSINESS OR INDUSTRY LABORER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WEBSTER				14. MOTHER'S MAIDEN NAME LENA EWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 07 8210		17. INFORMANT Address MRS HELEN WEBSTER CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease. DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 5 Min.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.				DATE SIGNED 6/13/59			
22. DATE OF CREMATION, REMOVAL (Specify)		22b. DATE OF BURIAL		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
JUN 14, 1959		JUN 14, 1959		DORCHESTER MEN PARK		CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMBIE FUNERAL SERVICE CAMBRIDGE MARYLAND				24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

